

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
18041					18038				
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wor.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R-Whaleysville</u>			c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Whaleysville</u> 23.1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____					e. STREET ADDRESS _____			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Alton</u> Last <u>Armstrong</u>					4. DATE OF DEATH Month <u>Dec</u> Day <u>24</u> Year <u>1966</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5/16/08</u>		9. AGE (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Edward Armstrong</u>					14. MOTHER'S MAIDEN NAME <u>Annie Dale</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. _____		17. INFORMANT <u>State Police</u> Address _____				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exposure</u> <u>932.8</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Alcoholic intoxication</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>								INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Evidently became intoxicated by alcoholic ingestion and fell in ditch and died from exposure.</u>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. - 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Ditch</u>		20f. (City or town) (County) (State) <u>Whaleysville Wor. Md.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>F. J. Townsend, Jr.</u>					22. DATE SIGNED <u>Dec 24, 66</u>				
EXAMINER'S NAME (Type) <u>F. J. Townsend, Jr.</u>					Address (Street, city, town, or county) <u>State Dept. of Health</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>12-30-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Whaleysville</u>		23d. LOCATION (City, town or county) (State) <u>Whaleysville, Md.</u>		
24. FUNERAL DIRECTOR <u>Loetta B. Jolley</u> Address <u>Jolley's Funeral Chapel Jersey Rd. Ht. 42 Sal.</u>					25a. REC'D BY REGISTRAR <u>DEC 28 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

18034

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18034

FOR STATE

10 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
18042					18039						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)						
a. COUNTY Worcester					a. STATE Maryland						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Bishopville					b. COUNTY Worcester						
c. LENGTH OF STAY IN 1b 57 Yrs					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishopville						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) XX					d. STREET ADDRESS						
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			5. SEX			6. COLOR OR RACE		
First LEVIN Middle JAMES Last COLLINS			Month Dec. Day 3 Year 1966			Male			White		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH			9. AGE (In years last birthday)			10. UNDER 1 YEAR		
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Aug. 15, 1881			85 yrs.			Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer			10b. KIND OF BUSINESS OR INDUSTRY Own Farm			11. BIRTHPLACE (County & State, or foreign country) Delaware			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Levin D. Collins						14. MOTHER'S MAIDEN NAME Elizabeth Murray					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) XX						16. SOCIAL SECURITY NO. 215-36-0301		17. INFORMANT Ethie Collins Bishopville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mixed tumor (R) parathyroid gland 142.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 142.0 OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 2 years					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 30-July, 1966 , to 3-Dec, 1966 , that (I) (we) last saw the deceased alive on 1-Dec 2, 1966 , and that death occurred at 6:00 AM , from the causes and on the date stated above.											
22a. SIGNATURE Jack C. Lewis						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 12/3/66		
22c. PHYSICIAN'S NAME (Type) Jack C. Lewis						22d. ADDRESS Selbyville, Del.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12/5/66			23c. NAME OF CEMETERY OR CREMATORY Oak Fellows			23d. LOCATION (City, town or county) (State) Bishopville, Md.		
24. FUNERAL DIRECTOR Peter Whaley Selbyville, Del.						25a. REC'D BY REGISTRAR DEC 5 1966			25b. REGISTRAR'S SIGNATURE Charles Judge		

18038

RECEIVED

18038

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

18043

CERTIFICATE OF DEATH

18040

Item #1d File #103 12/16/66

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>				c. LENGTH OF STAY IN 1b <u>23.1</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RFD Hays Landing Rd. (at home)</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>HENRY</u> Last <u>EVANS</u>				4. DATE OF DEATH Month <u>DEC</u> Day <u>7</u> Year <u>1966</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARM</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Whaleyville</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>DAVID EVANS</u>		14. MOTHER'S MAIDEN NAME <u>CHARLOTTE PAISY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-12-0915</u>		17. INFORMANT <u>Mrs. Andy Evans</u>		Address <u>Berlin Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis, acute attack</u> 502.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Chr. Nephritis</u> DUE TO (c) <u>Chr. Bronchitis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>13 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar 20</u> , 19 <u>66</u> , to <u>Dec 7</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec 6</u> , 19 <u>66</u> , and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Chas R Law</u>				22b. DATE SIGNED <u>12-8-66</u>		22c. PHYSICIAN'S NAME (Type) <u>Chas R Law</u>	
22d. ADDRESS <u>Berlin Md.</u>				22e. REC'D BY REGISTRAR <u>Charles Judge</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/9/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LEWIS</u>		23d. LOCATION (City, town or county) (State) <u>Willards Wis. Md</u>	
24. FUNERAL DIRECTOR <u>Anne A. Burboye</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				DATE <u>DEC 12 1966</u>			

1800

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18044

CERTIFICATE OF DEATH

18041

1. PLACE OF DEATH a. COUNTY Worcester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Stockton c. LENGTH OF STAY IN 1b 23.1 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holland Nurseing Home		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill d. STREET ADDRESS Market Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Martha Elizabeth Evans		4. DATE OF DEATH Month Day Year Dec. 23 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 23, 1878
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Whaleyville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert H. Davis		14. MOTHER'S MAIDEN NAME Erexine Dixon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Mrs. Ethel Gladding, Snow Hill, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis. DUE TO (c) Arterio sclerosis.		INTERVAL BETWEEN ONSET AND DEATH 12 h. 10 h. Years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of rectum		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 19 63 , to Dec. 19 66 that (I) (we) last saw the deceased alive on Dec 22 19 66 , and that death occurred at 12 24 66 M, from causes and on the date stated above.			
22a. SIGNATURE David Rafat		22b. DATE SIGNED 12-24-66	
22c. PHYSICIAN'S NAME (Type) DAVID RAFAT		22d. ADDRESS Snow Hill MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/26/66	
23c. NAME OF CEMETERY OR CREMATORY Bates Methodist		23d. LOCATION (City or Town) (County) (State) Snow Hill, Maryland	
24. FUNERAL DIRECTOR Charles Judge		25a. REC'D BY REGISTRAR DEC 28 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

1904

STATE OF TEXAS

1904

County of _____ State of _____
I, _____, Clerk of said County, do hereby certify that _____
of the County of _____ State of _____
has been duly elected _____
for the term of _____ years, to begin on _____
and to continue until _____
at which time he shall qualify for office.
Witness my hand and the seal of said County at _____
this _____ day of _____ 1904.

Clerk of County

Notary Public

Witness

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18045

CERTIFICATE OF DEATH

18042

1. PLACE OF DEATH a. COUNTY Worcester		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill		23.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 213 Petitt St.				d. STREET ADDRESS 213 Petitt St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Alice		First Middle Last - Jones		4. DATE OF DEATH Month Day Year December 29 1966			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH March 1, 1916		9. AGE (In years last birthday) yrs. 50	IF UNDER 1 YEAR Months Days Hours Min. 29 19 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Chicken Plant		11. BIRTHPLACE (County & State, or foreign country) Norfolk, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-05-0346		17. INFORMANT Willie Jones, New Castle, Del.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE DEHYDRATION DUE TO (b) ACUTE GASTRO ENTERITIS DUE TO (c) ACUTE GASTRO ENTERITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 4 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 28 , 19 66 , to Dec 29 , 19 66 , that (I) (we) last saw the deceased alive on Dec 28 , 19 66 , and that death occurred at 2A M, from causes on and on the date stated above.							
22a. SIGNATURE Robert C. La Mar, M.D.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12-30-66	
22c. PHYSICIAN'S NAME (Type) Robert C. La Mar, M.D.				22d. ADDRESS Snow Hill, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 2, 1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Baptist		23d. LOCATION (City or Town) (County) (State) Snow Hill, Maryland	
24. FUNERAL DIRECTOR Charles E. Judge				ADDRESS Snow Hill, Maryland		25a. REC'D BY REGISTRAR JAN 3 1967	
				25b. REGISTRAR'S SIGNATURE Charles E. Judge			

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UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

1894

STATE OF NEW YORK

1894

No. 1		No. 2		No. 3		No. 4		No. 5		No. 6		No. 7		No. 8		No. 9		No. 10		No. 11		No. 12		No. 13		No. 14		No. 15		No. 16		No. 17		No. 18		No. 19		No. 20		No. 21		No. 22		No. 23		No. 24		No. 25		No. 26		No. 27		No. 28		No. 29		No. 30		No. 31		No. 32		No. 33		No. 34		No. 35		No. 36		No. 37		No. 38		No. 39		No. 40		No. 41		No. 42		No. 43		No. 44		No. 45		No. 46		No. 47		No. 48		No. 49		No. 50		No. 51		No. 52		No. 53		No. 54		No. 55		No. 56		No. 57		No. 58		No. 59		No. 60		No. 61		No. 62		No. 63		No. 64		No. 65		No. 66		No. 67		No. 68		No. 69		No. 70		No. 71		No. 72		No. 73		No. 74		No. 75		No. 76		No. 77		No. 78		No. 79		No. 80		No. 81		No. 82		No. 83		No. 84		No. 85		No. 86		No. 87		No. 88		No. 89		No. 90		No. 91		No. 92		No. 93		No. 94		No. 95		No. 96		No. 97		No. 98		No. 99		No. 100		No. 101		No. 102		No. 103		No. 104		No. 105		No. 106		No. 107		No. 108		No. 109		No. 110		No. 111		No. 112		No. 113		No. 114		No. 115		No. 116		No. 117		No. 118		No. 119		No. 120		No. 121		No. 122		No. 123		No. 124		No. 125		No. 126		No. 127		No. 128		No. 129		No. 130		No. 131		No. 132		No. 133		No. 134		No. 135		No. 136		No. 137		No. 138		No. 139		No. 140		No. 141		No. 142		No. 143		No. 144		No. 145		No. 146		No. 147		No. 148		No. 149		No. 150		No. 151		No. 152		No. 153		No. 154		No. 155		No. 156		No. 157		No. 158		No. 159		No. 160		No. 161		No. 162		No. 163		No. 164		No. 165		No. 166		No. 167		No. 168		No. 169		No. 170		No. 171		No. 172		No. 173		No. 174		No. 175		No. 176		No. 177		No. 178		No. 179		No. 180		No. 181		No. 182		No. 183		No. 184		No. 185		No. 186		No. 187		No. 188		No. 189		No. 190		No. 191		No. 192		No. 193		No. 194		No. 195		No. 196		No. 197		No. 198		No. 199		No. 200		No. 201		No. 202		No. 203		No. 204		No. 205		No. 206		No. 207		No. 208		No. 209		No. 210		No. 211		No. 212		No. 213		No. 214		No. 215		No. 216		No. 217		No. 218		No. 219		No. 220		No. 221		No. 222		No. 223		No. 224		No. 225		No. 226		No. 227		No. 228		No. 229		No. 230		No. 231		No. 232		No. 233		No. 234		No. 235		No. 236		No. 237		No. 238		No. 239		No. 240		No. 241		No. 242		No. 243		No. 244		No. 245		No. 246		No. 247		No. 248		No. 249		No. 250		No. 251		No. 252		No. 253		No. 254		No. 255		No. 256		No. 257		No. 258		No. 259		No. 260		No. 261		No. 262		No. 263		No. 264		No. 265		No. 266		No. 267		No. 268		No. 269		No. 270		No. 271		No. 272		No. 273		No. 274		No. 275		No. 276		No. 277		No. 278		No. 279		No. 280		No. 281		No. 282		No. 283		No. 284		No. 285		No. 286		No. 287		No. 288		No. 289		No. 290		No. 291		No. 292		No. 293		No. 294		No. 295		No. 296		No. 297		No. 298		No. 299		No. 300		No. 301		No. 302		No. 303		No. 304		No. 305		No. 306		No. 307		No. 308		No. 309		No. 310		No. 311		No. 312		No. 313		No. 314		No. 315		No. 316		No. 317		No. 318		No. 319		No. 320		No. 321		No. 322		No. 323		No. 324		No. 325		No. 326		No. 327		No. 328		No. 329		No. 330		No. 331		No. 332		No. 333		No. 334		No. 335		No. 336		No. 337		No. 338		No. 339		No. 340		No. 341		No. 342		No. 343		No. 344		No. 345		No. 346		No. 347		No. 348		No. 349		No. 350		No. 351		No. 352		No. 353		No. 354		No. 355		No. 356		No. 357		No. 358		No. 359		No. 360		No. 361		No. 362		No. 363		No. 364		No. 365		No. 366		No. 367		No. 368		No. 369		No. 370		No. 371		No. 372		No. 373		No. 374		No. 375		No. 376		No. 377		No. 378		No. 379		No. 380		No. 381		No. 382		No. 383		No. 384		No. 385		No. 386		No. 387		No. 388		No. 389		No. 390		No. 391		No. 392		No. 393		No. 394		No. 395		No. 396		No. 397		No. 398		No. 399		No. 400		No. 401		No. 402		No. 403		No. 404		No. 405		No. 406		No. 407		No. 408		No. 409		No. 410		No. 411		No. 412		No. 413		No. 414		No. 415		No. 416		No. 417		No. 418		No. 419		No. 420		No. 421		No. 422		No. 423		No. 424	
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FOR STATE
HEALTH DEPT.

18046

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18043

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark		23.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Federal & Washington Sts.				d. STREET ADDRESS Bay Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle HENRY Last KUNKEL				4. DATE OF DEATH Month December Day 13 Year 1966			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 13, 1893		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months 8 Days 0	IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Engineer (Retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Philadelphia, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sebastiane Kunkel				14. MOTHER'S MAIDEN NAME Ottile Linder			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes War I		16. SOCIAL SECURITY NO. 160-09-4850		17. INFORMANT Mrs. Evalyn M. Kunkel (Wife) Bay Street, Newark, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Acute Myocardial infarction DUE TO (b) Arteriosclerotic Heart DUE TO (c) Disease						INTERVAL BETWEEN ONSET AND DEATH Minutes Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Was taking drivers Test						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No external injury					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Fed. & Wash. St.		20f. (City or town) (County) (State) Snow Hill Worcester Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE David Rafat		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED Dec. 15 / 1966	
EXAMINER'S NAME (Type) Dr. David Rafat, 104 N. Bay Street		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) Snow Hill, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 16, 1966		23c. NAME OF CEMETERY OR CREMATORY Bowen Cemetery		23d. LOCATION (City or Town) (County) (State) Newark, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR DEC 19 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

10081

10031

10031

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 501 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18047

18044

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Bishop</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Selbyville</u>			
c. LENGTH OF STAY in 1b <u>Transient</u>				d. STREET ADDRESS <u>Railroad Ave</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 113-</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Mitchell</u> Last <u>III</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>3</u> Year <u>1966</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 16 1937</u>		9. AGE (In years last birthday) <u>29</u> yrs.		10. UNDER 1 YEAR Months <u>29</u> Days <u>29</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chicken</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INDUSTRY</u>		11. BIRTHPLACE (State or foreign country) <u>Selbyville, Del</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Mitchell JR.</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Handy</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>221-22-4843</u>		17. INFORMANT <u>Mother Anna P. Mitchell</u> Address <u>Selbyville, Del.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractures, skull, femur, jaw, arm etc.</u> 823.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Due to</u> (c) <u>Due to</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>DRIVING CAR hit large tree head on.</u>			
20c. TIME OF INJURY Month, Day, Year <u>115</u> Hour <u>a.m.</u> <u>Dec 3</u> <u>1966</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>R 113</u>		20f. (City or town) (County) (State) <u>Rural Bishop</u> <u>Wor Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>J. Townsend Jr.</u>				22. DATE SIGNED <u>Dec 3, 66.</u>			
EXAMINER'S NAME (Type) <u>F. S. Townsend Jr.</u>				DEPUTY MEDICAL EXAMINER <u>Dr. Charles Judge</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/8/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Long's Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Selbyville, Dela.</u>	
24. FUNERAL DIRECTOR <u>Richard T. Watson</u> ADDRESS <u>Selbyville, Dela.</u>				25a. REC'D BY REGISTRAR <u>DEC 6 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1904

1904

1904

Handwritten notes and signatures, including names like "W. H. H. H." and "J. H. H. H.".

Vertical text on the right margin, possibly a date or page number.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18048

CERTIFICATE OF DEATH

18045

1. PLACE OF DEATH a. COUNTY Worcester		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden (Rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route # 1		d. STREET ADDRESS Route # 2	
3. NAME OF DECEASED (Type or print) DELLA V. PHILLIPS		4. DATE OF DEATH Month December Day 27 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 5, 1881
9. AGE (In years last birthday) yrs. 85		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Worcester County		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Shockley		14. MOTHER'S MAIDEN NAME Elizabeth Dickerson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Rt. #1		18. ADDRESS Henry Shockley, Eden, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 153.9 IMMEDIATE CAUSE (a) Toxemia DUE TO (b) Cancer of Intestine Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 5 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec 13, 1966 , to Dec 27, 1966 , that (I) (we) last saw the deceased alive on Dec 26, 1966 , and that death occurred at ----- M, from causes and on the date stated above.			
22a. SIGNATURE B. Frank Giganti		22b. DATE SIGNED Dec 28, 1966	
22c. PHYSICIAN'S NAME (Type) B. Frank Giganti MD		22d. ADDRESS Princess Anne, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 30, 1966	23c. NAME OF CEMETERY OR CREMATORY Mt. Olive	23d. LOCATION (City or Town) (County) (State) Snow Hill Maryland
24. FUNERAL DIRECTOR Swald & Saunders		25a. REC'D BY REGISTRAR Charles Judge	
ADDRESS Snow Hill, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18045

CERTIFICATE OF BIRTH

18045

DATE OF BIRTH

(DAY) (MONTH) (YEAR)

TIME

PLACE

NAME OF FATHER

NAME OF MOTHER

NAME OF CHILD

NAME OF CHILD

NAME OF CHILD

NAME OF CHILD

NAME OF CHILD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div> <div>1</div> <div> <div>18049</div> <div>18046</div> </div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div>									
1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> c. LENGTH OF STAY IN 1b <u>All Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> 23.1 d. STREET ADDRESS <u>Rt #3 Box 133</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY M. Purnell</u>					4. DATE OF DEATH Month Day Year <u>12 11 1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-15-1883</u>		9. AGE (In years last birthday) <u>83</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Worcester</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Clay Jassett</u>					14. MOTHER'S MAIDEN NAME <u>MARTHA Porter</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>214-32-5031</u>		17. INFORMANT Address <u>Anna Smack Rt #3 Berlin, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac degeneration</u> 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Cardio-vascular Disease</u> DUE TO (c) <u>Essential Hypertension</u>									INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>5 yrs.</u> <u>12 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Varicose ulcer, right leg</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>5/7/54 4:30 PM</u> to <u>12/11/66</u> , 19 <u>66</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>12/11/66</u> 19 <u>66</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Ivory U. Sully, Jr.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>								22b. DATE SIGNED <u>12/13/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ivory U. Sully, Jr., MD</u>								22d. ADDRESS <u>P. O. Box 126, Berlin, Md. 21811</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>12-17-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>		23d. LOCATION (City, town or county) (State) <u>Berlin Md.</u>		
24. FUNERAL DIRECTOR <u>Louella B. Jolley</u> ADDRESS <u>Jolley Memorial Chapel, 1001 N. Salisbury St., Berlin, Md.</u>					25a. REC'D BY REGISTRAR <u>DEC 21 1966</u> DATE				
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>									

1844

CONTINUATION OF REPORT

1844

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
18050					18047					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)					
a. COUNTY		Worcester			a. STATE		Maryland			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Whaleyville			b. COUNTY		Worcester			
c. LENGTH OF STAY IN 1b		life			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Whaleyville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		XX			d. STREET ADDRESS		RD			
e. IS RESIDENCE ON A FARM?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
First		Middle		Last		Month		Day Year		
Charles		H.		Smith		Dec. 17,		1966 19		
5. SEX	6. COLOR OR RACE	7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			
Male	White	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Oct. 29, 1900	66 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?				
Farmer		Own Farm		Maryland		U S A				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME					
Max Smith					Lucy Jones					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.		17. INFORMANT Address			
(If yes give war or dates of service)					212-16-1414		Helen Smith Whaleyville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Coronary Thrombosis										
260X DUE TO (b) Hypertension										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Diabetes										
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year					20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m. 19					While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from 1966 to 1966, that (I) (we) last saw the deceased alive on Dec 4 1966 and that death occurred at 3:30 P.M. from the causes and on the date stated above.										
22a. SIGNATURE					22b. DATE SIGNED					
Clifford E. Schott					1966 Dec 17					
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS					
Clifford E. Schott M.D.					Berlin, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial			12/20/66		Farlow		Pittsville, Md.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Peter Whaley Selbyville, Del.					DATE DEC 21 1966		Charles Judge			

18043

04031

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18051

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18048

1. PLACE OF DEATH a. COUNTY Worcester				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Federal St.				d. STREET ADDRESS Federal St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARGUERITE (MARGIE) DAVIS STAGG				4. DATE OF DEATH December 3 19 66							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 23 1888		9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U S A				13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No -				16. SOCIAL SECURITY NO. 218-20-4680				17. INFORMANT Mr. Edward Davis, Balt. Md. 21212			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic and</u> DUE TO (c) <u>hypertensive Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>few min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Exposure to cold.</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) David Rafat MD, Snow Hill, Worcester Maryland				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED 12-4-66			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Dec. 5, 1966		23c. NAME OF CEMETERY OR CREMATORY London Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR ADDRESS Snow Hill, Md.						25a. REC'D BY REGISTRAR DATE DEC 3 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

1904

BY

SPRINGER

THE SPRINGER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
18052					18049						
1. PLACE OF DEATH a. COUNTY Worcester					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Berlin					b. COUNTY Worcester						
c. LENGTH OF STAY IN 1b					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishopville Rural 23.1						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS Bishopville Rural 23.1						
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Virginia V. Waters					4. DATE OF DEATH Month Day Year Dec. 9, 1966						
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/15 / 1904		9. AGE (In years last birthday) 62 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) maid		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Worcester County Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Sam Edgar Purnell					14. MOTHER'S MAIDEN NAME Harriet Porter						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no					16. SOCIAL SECURITY NO. 195-05-1490		17. INFORMANT Carter Waters				
					Address Bishopville, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocarditis DUE TO (c) 1st pertension										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 12-8-66 to 12-9-66, that (I) (we) last saw the deceased alive on 12-8-66, and that death occurred at 9:30 AM, from the causes and on the date stated above.											
22a. SIGNATURE Clifford E. Schott M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) Clifford E. Schott M.D.					22d. ADDRESS Berlin, Maryland						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 12/12/66		23c. NAME OF CEMETERY OR CREMATORY Showell Cem.		23d. LOCATION (City, town or county) (State) Showell, Maryland				
24. FUNERAL DIRECTOR Richard T. Watson					ADDRESS Selbyville, Del.		25a. REC'D BY REGISTRAR DATE DEC 13 1966		25b. REGISTRAR'S SIGNATURE J Charles Judge		

1894

1895



RECEIVED

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